STATE OF KANSAS
DEPARTMENT OF HEALTH AND ENVIRONMENT
DIVISION OF HEALTH CARE FINANCE

NOTIFICATION OF KANCARE/HCBS/MFP/WH/WORK SERVICES CHANGES/UPDATES

ES-3161
Rev. 01-13

TO: _____ **FROM:** _____

ADDRESS: _____ **ADDRESS:** _____

_____ _____

I. CONSUMER INFORMATION

Name: _____

Case Number (if known): _____ KanCare ID No.: _____

Address Change: _____ Date: _____

Responsible Person or Contact Change: _____ Date: _____

II. KANCARE INFORMATION CHANGES (to be completed by DCF eligibility staff)

☐ Review Complete: ☐ Approved/Denied ☐ Working Healthy/WORK – Temporary Unemployment Plan Needed

Review Effective Date: _____ Next Review Due:: _____ Date Last Employed: _____

☐ HCBS/MFP Client Obligation Change: $ _____ Effective: _____ Reason For Unemployment: _____

$ _____ Effective: _____ _____

☐ KanCare Case Closed Effective: _____ Reason For Closure: _____

☐ HCBS/MFP Client Employed – Possible Working Healthy/WORK Eligibility

☐ Other: _____

Comments: _____

III. HCBS/MFP/WORK SERVICE CHANGES (to be completed by Case Manager or WORK Manager)

☐ HCBS/MFP/WORK Services Review Complete: ☐ Approved ☐ Denied Effective Date: _____

☐ Level of Care Waiver Change To: _____ Effective Date: _____

☐ Monthly Cost of Care Change To: $ _____ Effective Date: _____

☐ HCBS/MFP/WORK Services Terminated: Effective Date: _____ Reason: _____

☐ Medical Bills For Client Obligation (bills attached)

☐ Entered Nursing Facility: Date Entered: _____ Facility: _____

Anticipated Length of Stay: _____ Stay is: ☐ HCBS Covered Respite Care ☐ Temporary Care ☐ Permanent/Undetermined

☐ Other: _____

Comments: _____

IV. WORKING HEALTHY INFORMATION (to be completed by Benefit Specialist)

☐ Temporary Unemployment Plan Information: ☐ Plan Developed ☐ Client Failed to Comply – Reason: _____

☐ Premium Repayment: ☐ Agreement Signed – Date Received: _____

☐ Other: _____

Comments: _____

_____ Attachments: ☐ Yes ☐ No
DCF Eligibility Worker Signature Date

_____
HCBS/MFP/Working Healthy/WORK Authorized Agent Signature Date